



Care Management Referral Form- Southwest Region

Please use this form to refer a Buckeye Health Plan member to the Care Management Program

Date: _____

Member Name: _____

Member's Date of Birth: _____

MMIS ID #: _____

Member Address: _____

Member Phone #: _____

Please check the reason for the referral:

- Non Compliance to treatment plan
- Complex Medical Issues
- High Emergency Room usage
- Multiple Hospitalizations
- Social Service Issues
- Mental Health Issues
- Education regarding disease management/self management skills
- High Risk Pregnancy/Please attach Notification of Pregnancy
- Other (explain): _____

Please use the space below to give details about the referral

Provider Name: _____

Provider Phone & Fax Number: _____

Requested by: _____

Please fax this form to:

1-866-528-9920

Or you may call referrals to:

1-866-246-4359